SECTION 2

HOSPITAL SERVICES

Table of Contents

1 GENERAL POLICY

Hospital services are available to eligible Medicaid clients with surgical, medical, diagnostic, or level of care needs which require the availability of specialized diagnostic and therapeutic services, and close medical supervision of care and treatment directed toward maintenance, improvement, or protection of health or lessening of illness, disability or pain.

A hospital which accepts a Medicaid patient for treatment accepts the responsibility to make sure that the patient receives **all** medically necessary services from **Medicaid** providers. This includes physicians, surgeons, anesthesiologists, laboratory, X-ray, pharmacy, rehab and other providers on staff. The hospital administration is accountable for the quality of care provided to patients. Quality care includes the provision of care by practitioners who meet all requirements of the Utah Medicaid program, who agree to abide by Medicaid rules to provide medically necessary services, and who accept the Medicaid reimbursement as payment in full.

If providers (including but not limited to anesthesiologists) do not accept a particular patient for treatment, or will not accept the Medicaid payment as payment in full, the hospital is still responsible for assuring delivery of medically necessary services.

Should the Medicaid client receive medically necessary services from a non-Medicaid provider, the hospital is financially responsible for covering the services. Neither the provider nor the hospital may bill the patient for such services. For example, if the hospital's anesthesiologist does not accept Medicaid as payment in full, the hospital must provide an anesthesiologist who will accept the payment without requiring a co-payment or any other charge. Under federal Medicaid law, pregnant women in particular may not be subjected to cost sharing for Medicaid services.

A. *Inpatient Hospital* services can only be provided appropriately by bed occupancy for 24 hours or more in an approved acute care general hospital; must be provided to a client under the care of a physician or dentist; and must be furnished in an institution that:

   (1) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

   (2) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

   (3) Meets the requirements for participation in Medicare as a hospital; and

   (4) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30 [October 1, 1996] which is incorporated by reference;

   (5) Has an interdisciplinary team, as specified in 42 CFR 441.153, which must certify and recertify the need for inpatient psychiatric services for individuals under age 21, as described in 42 CFR 441.152 [October 1, 1996 edition] which is incorporated by reference; and

   (6) Recognizes that all hospital admissions are subject to review by the Department for appropriateness and medical necessity.

For the purpose of documenting admission and length of stay, the day of admission to an acute care hospital facility is counted as a full day stay and the day of discharge is not counted.

Readmissions within 30 days for the same or similar principal diagnosis may be denied or, at the option of the State, be combined with the claim for the first admission. In the case of claims that are combined, it is assumed that the first DRG payment covers both admissions. Outlier days are paid when appropriate. For more information refer to Chapter 3, LIMITATIONS, item 18, Readmissions Within 30 Days of Previous Discharge.

When a patient receives either nursing facility-level of care or other sub-acute care in either an acute-care hospital or a swing bed approved hospital, reimbursement will be at the nursing facility rate.

Authority for *Inpatient Hospital* service is found at Section 1901, et seq., and Section 1905(a)(1) of the Social Security Act; 42 Code of Federal Regulations, Section 440.10 [October 1, 1996 edition], and Utah Code Annotated, Sections 26-1-5, 26-1-15, 26-18-6, and Subsections 26-18-3(2) and 26-18-5(3), and (4).

B. *Outpatient Hospital* service is preventive, diagnostic, therapeutic, rehabilitative, or palliative service. Covered services must be services that meet the following conditions:

(1) Are furnished to outpatients;

(2) Are furnished by or under the direction of a physician or dentist; and

(3) Are furnished by an institution that —

(a) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

(b) Meets the requirements for participation in Medicare as a hospital;

(4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

Outpatient hospital services are provided for less than 24 hours and must be medically necessary and appropriate to diagnose or treat illness, disability or pain.

The authority for Outpatient Hospital services is found in section 1901 et seq. and section 1905(a)(2) of the Social Security Act, and by 42 Code Of Federal Regulations 440.20 [October 1, 1996], and Utah code Annotated, Sections 26-1-5, 26-18-2.3, and by subsection 26-18-3(2).

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO) or Prepaid Mental Health Plan (PMHP), must receive all health care services through that plan. The name of the managed care plan responsible for the Medicaid client's care is specified on the Medicaid Identification Card. Refer to SECTION 1, General Information, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan.

For clients in need of emergency services and who are either enrolled in a managed care plan, or who may qualify for Medicaid, refer to Chapter 3, LIMITATIONS, item 25 B, Emergency Services for Clients in a Managed Care Plan.

Mental Health Services: Unless there are extenuating circumstances, a provider must request authorization from the client's Prepaid Mental Health Plan for inpatient mental health services within 24 hours of admission. If the provider does not have a contract with the PMHP responsible for the inpatient stay, the PMHP may choose to transfer the individual to one of its contracting hospitals. If you think an individual may qualify for Medicaid, you should contact the appropriate PMHP to obtain authorization for outpatient services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility. (See SECTION 1 of this manual, Chapter 1 - 3, Retroactive Medicaid). If so, the PMHP contractor will be responsible for services.

For more information about managed health care plans, refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs and PMHPs with which Medicaid has a contract to provide health care services is included as an attachment to this provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a fee-for-service claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Definitions

In addition to the definitions in R414-1 of the Utah Administrative Code and SECTION 1 of this Medicaid Provider Manual, the following definitions apply.

Admission

The acceptance of a Medicaid client for inpatient hospital care and treatment when the client meets established level of care criteria for severity of illness and intensity of service, and the required service can not be provided in an alternative setting.

Bundling

The concept used by Medicare and adopted by Medicaid, to cover all inpatient hospital services by the DRG — use of hospital facilities, technical portion of clinical laboratory and radiology services, nursing, therapy services, medical social services, and other related services furnished by the hospital as part of the general accommodations for inpatient service.

Clinical Laboratory Improvement Amendments (CLIA)

The federal Health Care Financing Administration program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

Diagnostic Related Group (DRG)

The system established to recognize and reimburse for the resources used to treat a client with a specific diagnosis or medical need. The DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files or from the U.S. Department of Health and Human Services, Health Care Financing Administration.

Hysterectomy

A surgical procedure or operation for the purpose of removing the uterus.

Inpatient Hospital Services

Services furnished in a facility maintained primarily for the care and treatment of inpatients with disorders other than mental disease, and furnished by or under the direction of a physician or other approved practitioner of the healing arts.

Intensive Inpatient Hospital Rehabilitation Service

An intensive rehabilitation program provided in an acute care general hospital through the services of a multidisciplinary, coordinated, team approach directed toward improving the ability of the patient to function.

Leave of Absence (LOA)

An absence from an inpatient facility for therapeutic or rehabilitative purposes where the patient does not return by midnight of the same day.

Observation

Observation services are those services, including use of a bed and monitoring by hospital staff, furnished by physician order, which are reasonable and necessary to evaluate the outpatient's condition or determine the need for a possible admission to the hospital. These services are short-term, lasting less than 24 hours.

Outlier Days

Those days by which a patient's length of stay in a hospital exceeds the predetermined limit for a specific service referred to as the "trim point" or "threshold". Outlier days are subject to prepayment review. There are no cost or charge outliers.

Other Practitioner of The Healing Arts

A doctor of osteopathy, doctor of dental surgery or dental medicine, or doctor of podiatric medicine.

Outpatient

An individual who receives professional services at a hospital for less than a 24 hour period.

Outpatient Hospital

A facility that --

(a) is in, or physically connected to, a hospital licensed by the Department as a general hospital, as defined by Section 26-21-2(8), and meets the standards set forth in R432-100, Utah Administrative Code, and 42 CFR Part 482 [October 1, 1996 edition];

(b) meets the requirements for participation in the Medicare program; and

(c) has a current provider agreement with the Department.

Package Surgical Procedure

Bundling of preoperative office visits and preparation, the operation, local infiltration, topical or regional anesthesia when used, and the normal, uncomplicated follow-up care extending up to six weeks post-surgery.

Personal Supervision

Critical observation and guidance by a physician of a nonphysician's activities within the nonphysician's licensed scope of service.

Sterilization

Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Take Home Supplies

Medical supplies or equipment to be used by the patient at home for follow-up care.

Technical Component

That part of laboratory or radiology service, provided with hospital supplies or equipment, necessary to secure a specimen and prepare it for analysis, or to take an x-ray and prepare it for reading and interpretation

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Triage Fee

The fee established for payment to the Emergency Department physician who completes an initial evaluation, determination, and subsequent referral back to the primary care physician because the severity of symptoms demonstrated by a patient who presents with a complaint are not of an intensity requiring Emergency Department level of care.

UB-92 Manual

The Utah Uniform Billing Instruction Manual developed and maintained by the Association of Health Care Providers which contains information specific to third party payors and billing instructions for use of the UB-92 Inpatient and Outpatient billing form seeking reimbursement for services.

2 COVERED SERVICES

All hospital inpatient and outpatient services are subject to review by the Department of Health for medical necessity and appropriateness of the admission according to R414-1-12 and R414-1-14 of the Utah Administrative Code.

1. *Inpatient Hospital* services encompass medically necessary, therapeutic Medicaid services and supplies that are ordered by a physician or other practitioner of the healing arts and are appropriate for the adequate diagnosis and treatment of a patient's illness. These services include use of hospital facilities, the technical portion of clinical laboratory and radiology services, nursing, medical social services, and therapy services.

   Inpatient Stay Defined

   An inpatient stay is defined as an admission which meets established criteria for severity of illness and intensity of service and the patient receives room, board, and professional services in the institution for 24 hours or more. If the patient remains less than 24 hours, the inpatient definition still applies if the patient:

   A. Is admitted for a normal delivery;

   B. Is admitted and expires; or

   C. Is admitted and is then transferred to a distinct-part or another acute care hospital.

*

   Continuing Care/Admission Following Outpatient Surgery

   The Health Care Financing Administration has provided direction for the coding of services for patients admitted for continuing care following outpatient surgery. (Health Care Financing Administration Region VIII letter 91-26.)

   A. Vague symptoms should be coded as V58.8 — Other Aftercare Following Surgery

      A physician may be concerned about the progress the patient is making after outpatient surgery. The patient may not have any clearly identifiable, specific condition that leads to the admission. However, several factors such as pain, nausea, or slow recovery from anesthesia, in combination with the general progress and condition of the patient may lead the physician to admit the patient for closer monitoring.

   B. Well defined symptoms that are identified by the physician should be coded as the reason for the admission using the ICD-9-CM diagnosis for that specific condition. An example is post operative hemorrhage 998.1

      The admission hour, in these instances, is the hour the patient is actually admitted as an inpatient.

   C. If the patient leaves the hospital as scheduled after outpatient surgery and is later admitted as an inpatient, the principal diagnosis on the claim should be the ICD-9-CM diagnosis code which is the reason for the admission. An example is Pneumonia 997.3 or post operative wound infection 998.5.

2. Diagnostic services performed by the admitting hospital or by an entity wholly owned or operated by the hospital within three days prior to the date of admission to the hospital are deemed to be inpatient services and are covered under the DRG.

3. Drugs and biologicals appropriate for inpatient care and approved by the federal Food and Drug Administration are covered Medicaid services based on individual need and physician's written order. The drug must be given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug. Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services. A copy of the Pharmacy Manual is available on the Internet (www.health.state.ut.us/medicaid/pharmacy.pdf) or contact Medicaid Information.

4. Medical supplies, appliances, and equipment required for the care and treatment of a client during an inpatient stay are covered Medicaid services under the DRG, provided four conditions are met: (1) The supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are listed on the Medical Supplies List. This list is included with two Utah Medicaid Provider Manuals: Physician Services and Medical Suppliers. Coverage requirements are described in the manual for medical suppliers. A copy of the list or the Medical Suppliers Manual may be obtained by contacting Medicaid Information.

5. Services associated with pregnancy, labor and delivery are covered under the DRG as inpatient service, even if the stay is less than 24 hours, when the patient is an admitted hospital inpatient for a normal vaginal delivery or a C-section delivery.

   False Labor
   False labor may occur after 37 completed weeks of gestation. At this point in a pregnancy, changes begin to occur, and contraction-like activity may be present. It is often difficult to identify true labor, especially for a first time mother. If the threatened labor is of such a nature that a hospital admission is determined necessary by the physician, but does not progress to delivery through the current admission, a payment separate from the global maternity fee can be made for the service. The hospital should identify the admission with ICD.9.CM code 644.13 and appropriately selected Evaluation and Management codes. Repeated admissions through the final three weeks of pregnancy will be reviewed through the post payment review process.

6. Organ transplantation services are covered Medicaid services as specified in R414-10A, Utah Administrative Code.

7. Inpatient and outpatient hospital psychiatric services are covered under the Medicaid fee-for-service program for clients not enrolled in a Prepaid Mental Health Plan. Inpatient service is approved only when care needs are determined by established criteria and utilization review standards to be of such severity and intensity that appropriate service cannot be provided in any alternate setting.

8. *Outpatient Hospital* services are medically necessary diagnostic and therapeutic services or supplies that are ordered and supervised by a physician or other practitioner of the healing arts, and are appropriate for the adequate diagnosis or treatment of a client's illness. Outpatient hospital services include:

   A. Nursing services or other personnel services necessary to provide patient care;

   B. The use of hospital facilities, equipment, and supplies; and

   C. The technical portion of clinical laboratory and radiology services.

   The fee paid for an outpatient hospital service incorporates utilization of these elements.

9. ALL rehabilitation services require prior approval from Medicaid. Requirements and criteria for rehabilitation services are specified in the attachment *Rehabilitation Program*.

   A. Inpatient hospital intensive physical rehabilitation services are covered Medicaid services, as specified in R414-2B, Utah Administrative Code.

   B. Outpatient rehabilitation service is a special, limited service covered for individual clients who qualify and who have neither received nor qualify for the intensive, inpatient physical rehabilitation program. Prior authorization may be given based on established criteria.

   C. For approval, rehabilitation services must meet the following criteria:
      (1) The patient is medically and surgically stable.
      (2) This is the first admission, or the patient has developed a new problem, and now meets other admission criteria.
      (3) The patient has a reasonable expectation of improvement in his/her activities of daily living which are appropriate for his/her chronological age and development that will be of significant functional improvement when measured against his/her documented condition at the time of the initial evaluation.
      (4) The patient requires **close medical supervision** by a physician with specialized training or experience in rehabilitation.
      (5) The patient requires 24-hour nursing care or supervision by a registered nurse with specialized training or experience in rehabilitation.
      (6) **The patient's cognitive and sensory capacity allows active participation in an intense rehabilitation program which includes, at a minimum, 3 hours of physical and/or occupational therapy and/or speech therapy in addition to any other necessary therapeutic disciplines which will restore function rather than maintain existing function at the time of admission, 5 ½ days/week.**

   D. The physician or his/her designee must initiate the request for prior authorization no later than the 5th working day after admission to the Rehab Unit. The request can be made by telephone, by FAX, or in writing. The request can be initiated before the patient is admitted to the Rehab Unit if there is sufficient documentation to substantiate the request for admission. The information required information for a request is as follows:
      (1) Telephone contact: Information must be sufficient to complete the Medicaid Rehab intake worksheet.
      (2) Fax (538-6382) or in writing:
         a. Completed Medicaid Rehab intake worksheet or
         b. Section I of the Medicaid Rehab intake worksheet completed with supporting documentation i.e.:
            - History and Physical

- Rehab evaluation, including patient goals and prognosis
- Physical therapy evaluation
- Occupational therapy evaluation
- Speech therapy evaluation with audiology evaluation, if applicable
- Nursing evaluation

Reminder: Coverage requirements apply **ONLY** when the Medicaid client is assigned to a Primary Care Provider or not enrolled in a managed care plan. Medicaid does **NOT** process Prior Authorization (PA) requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting PA for services to a client enrolled in a managed care plan will be referred to that plan.

E. At the time of the telephone contact, or receipt of the FAX, a decision will be made by Medicaid staff regarding the appropriateness of the admission. The provider will be informed via phone of the decision. A letter of approval, denial or pending status will be mailed to the provider.

F. Notice of Rights

(1) The Medicaid agency will give advance notice in accordance with State and Federal regulations whenever payment is not approved for services which prior authorization was requested. The notice will specify (1) the service(s) for which payment has not been authorized, (2) the reason(s) the authorization was not granted, (3) the regulations or rules which apply, and (4) the appeal rights of the provider.

(2) The physician and/or hospital may not charge the patient for services that are denied (1) because the provider failed to advise the patient that the services were not a covered Medicaid benefit, (2) because the provider failed to follow prior authorization procedures, or (3) because payment has been denied. The provider may charge the patient for services that are not covered by Medicaid only when the provider has advised the patient in advance that the services are not covered and the patient has agreed in writing to pay for the services. Refer to SECTION 1, General Information, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients..

2 - 1 Co-payment Requirements for Hospital Services

Many adult Medicaid clients are required to make a co-payment for hospital services. Both HMO and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-pay is required and for what type of services. The provider is responsible to collect the co-pay at the time of service or bill the client. The amount of the client's co-pay will be deducted from the claim reimbursement.

Requirements specific to hospital services are stated below. For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, co-pay maximums, and an example of the co-pay message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

Medicaid requires a co-payment when the conditions listed below are met.

1. The Medicaid Identification Card must state a co-pay is required for the individual client. If there is not a co-pay message by a client's name, the client does not have a co-pay. Also, do not require a co-pay for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

2. The service must be subject to a co-pay. Hospital services subject to co-pay are non-emergency use of the emergency department, outpatient hospital, and inpatient hospital. Exceptions: Do not require a co-pay for family planning services, emergency services in a hospital emergency department, lab and X-ray services, including both technical and professional components, or anesthesia services.

   A. **Non-emergency Use of the Emergency Department**

      Except for exempt clients and exempt services described in items 1 and 2 above, Medicaid clients have a **$6.00** co-payment for non-emergency use of the Emergency Department. When a client comes to the Emergency Department for services, he or she should be assessed. If the condition is not an emergency, refer the client to his or her Primary Care Provider, or after-hours care if appropriate. If the client is referred, the hospital may bill a triage fee. Refer to Chapter 2 - 2, Emergency Department Reimbursement.

      Do not require a co-pay when the **discharge diagnosis** is one of those listed in the table attached titled Utah Medicaid Table of Authorized Emergency Diagnoses. Enter the discharge diagnosis on the claim as one of the first five diagnoses.

   B. **Outpatient Hospital Services**

      Except for exempt clients and exempt services described in items 1 and 2 above, effective November 1, 2001, Medicaid clients have a **$2.00** co-payment for outpatient hospital services.

   C. **Inpatient Hospital Services**

      Except for exempt clients and exempt services described in items 1 and 2 above, effective February 1, 2002, Medicaid clients have a **$220.00** co-insurance payment for inpatient hospital services.

2 - 2 Emergency Department Reimbursement

The **discharge diagnosis** is the basis for Medicaid reimbursement of emergency department services. Use the discharge diagnosis when billing for emergency department services and include it as one of the first five diagnoses listed on the claim. Only the codes and diagnoses listed in the Utah Medicaid Table of Authorized Emergency Diagnoses will be reimbursed at the emergency department reimbursement rate which is 98% of charges.

For clients enrolled in a managed care plan, refer to Chapter 1 - 1, Clients Enrolled in a Managed Care Plan, and Chapter 3, LIMITATIONS, item 25 B, Emergency Services for Clients in a Managed Care Plan.

A. Non-Emergency Diagnosis Reimbursement

Non-emergency services delivered through the emergency department are reimbursed at a rate lower than the rate for emergencies. The non-emergency rate for rural hospitals is 65% of charges. The non-emergency rate for urban hospitals is 40% of charges.

Medicaid clients may be required to make a co-payment for non-emergency use of the emergency department. Refer to Chapter 2 - 1, Co-payment Requirement: Outpatient Hospital and Non-emergency Use of a Hospital Emergency Department.

B. Triage Fee

If a client's medical needs are assessed and determined by the emergency room physicians to be routine, that is, not an emergency or of an urgent nature, refer the client to his or her Primary Care Physician for treatment. The hospital may bill revenue code 458 (triage fee). When a triage service is billed, no other medical care services will be paid by Medicaid for that date of service to the same provider for the same triage encounter.

3 LIMITATIONS

1. Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification only. Any continuing therapy must be accessed under the outpatient mental health or psychiatric services benefit as appropriate.

2. Cosmetic, reconstructive, or plastic surgery is limited to:
   (a) correction of a congenital anomaly;
   (b) restoration of body form following an accidental injury; or
   (c) revision of severe disfiguring and extensive scars resulting from neoplastic surgery.

3. Abortion procedures are limited to:
   (a) those where the pregnancy is the result of an act of rape or incest; or
   (b) a case with medical certification of necessity where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

   (42 CFR 441.203 and Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998.)

   (Note: Please note that the emphasis is on physical disorder or illness.)

4. Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441, Subpart F which is adopted and incorporated by reference.

   A. Voluntary Sterilization

   An individual decision made by the client, male or female, for the purpose of preventing conception, therefore, making the voluntary sterilization a benefit under family planning. The following criteria must be met:

   (1) A prior authorization must be obtained, by the physician, prior to the service being provided. (The prior authorization number will be provided to the facility identified by the physician as the place for the procedure.

   (2) A sterilization consent form (Form 499-A) must be signed.

   (3) A 30 day waiting period must be observed. The prior authorization will not become effective until 31 days after the date the consent form is signed.

   A hysterectomy, when no medical pathology is present, does not meet the criteria for a voluntary sterilization.

B. Sterilizations Incident To Surgical Procedures for Medical Reasons

The 30 day waiting period for sterilization does not apply where the sterilization is incident to a surgery that is performed for medical reasons, e.g., a tumor or cancer of the uterus, ovary, testes or prostate. Such surgical procedures require the following:

(1) Prior authorization obtained when possible before the procedure is completed. In the case of an emergency procedure, the authorization can be obtained before payment by the physician submitting documentation for review to support the emergency nature of the service.

(2) A hospital surgical consent must be provided with clear indication of the procedure(s) to which the patient consented. (This consent is different than the Form 499-A required for voluntary sterilization.)

(3) Documentation from the patient's medical record clearly showing the indications for the surgical procedure that resulted in sterilization.
Refer to SECTION 1, General Information, Chapter 9 - 7, Retroactive Authorization.

A complete list of criteria can be found in the attachment Criteria for Surgical Procedures. A sample Form 499-A, Hysterectomy Information and Consent Form, is also included with this manual.

5. Labor and delivery are considered emergency services for pregnant women who are eligible for "Emergency Services Program", as stated on the Medicaid Identification Card.

   Information about this program can be found in SECTION 1, Chapter 13 - 8, Emergency Services Program For Non-Citizens.

6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in R414-10A Utah Administrative Code. (Kidney and cornea transplantations are an exception and do not require prior authorization.)

   When an organ transplant procedure is done without authorization because the procedure does not meet the established criteria, payment will be denied for all services related to the transplant up to the outlier threshold days for the specific type of transplant. Medically necessary services beyond the initial denial period may be considered for payment.

7. Inpatient rehabilitation or psychiatric patient off-unit pass is limited to a written order by the attending physician. The written order should identify objectives of the pass which support the patient's plan of care, be planned by the physician and/or interdisciplinary team, and be documented and evaluated in the progress notes of the patient's chart upon return to the unit.

8. A therapeutic leave of absence is limited to inpatient rehabilitation patients to test their ability to manage in a community setting in preparation for discharge. Such leave is pursuant to a written order by the attending physician, planned by the physician and/or the interdisciplinary team, and adequately documented and evaluated in the progress notes of the patient's chart as supporting the patient's plan of care.

9. Review of inpatient "outlier days" is limited to cases where full payment of the DRG has been made to the hospital. The following exceptions apply:

   A. Neonatal admissions assigned to DRG's 385, 386, or 387 go into outlier status the day after admission. A length of stay less than 20 days does not require review. Payment will automatically be calculated to include the outlier days.

      If a case with stay of less than 21 days is submitted in error, the entire case will be reviewed for severity of illness and intensity of service.

   B. When the stay for a Medicaid patient eligible for Emergency Services Only goes into outlier days, the entire record must be submitted with a transmittal sheet for one review. The emergency circumstances and the outlier days can be evaluated in the same review – a benefit to both the hospital and the agency.

10. Readmissions Within 30 days of Previous Discharge

    When a hospital reimbursement is based on a diagnosis-related group (DRG) payment and a Medicaid client is readmitted to the hospital within 30 days of a previous discharge for the same or a similar diagnosis, Medicaid will evaluate both claims to determine if they should be combined into a single DRG payment or paid separately.

    Evaluation criteria are severity of illness, intensity of service, and cost-effectiveness. InterQual criteria are used to evaluate severity of illness and intensity of service.

    A. Both admissions must meet criteria for coverage in order to be considered for payment. Admissions that do not meet criteria will be denied, and the days associated with that admission will not be paid.

    B. If Medicaid staff decide to combine the claims into a single DRG, the first DRG payment covers both admissions. Appropriate outlier days will be paid based on the actual days of inpatient service.

    C. Reimbursement for multiple admissions for the same or a similar DRG within 30 days of the date of discharge are limited to no more than 110% of billed charges.

11. Exceptions to the 30 day readmission policy

    A. For a pregnancy or chemotherapy related diagnosis, a second DRG payment may be made when the client is readmitted to the hospital within 30 days of a previous discharge. Severity of illness and intensity of service requirements still must be met.

    B. Hyperbilirubinemia, jaundice of the newborn, appears in a certain percentage of newborn infants within the first week of life. Symptoms vary from mild to severe and life threatening. There is no way to predict which infants will develop symptoms of jaundice, and most infants are discharged from the hospital within a short time after birth,. According to the American Academy of Pediatrics, most healthy full term infants who develop jaundice may be safely managed as outpatients at home. However, the most severe cases will require hospitalization. Since hyperbilirubinemia is not easily detected, and hospitalization may be necessary, readmissions within 30 days will be exempt from initial review, and a second DRG may be paid.

       Exception cases will be subject to random selection and review as part of the regular utilization management review process.

12. Laboratory services are limited to those tests identified by the Health Care Financing Administration for which the individual laboratory is CLIA certified to provide, bill and receive Medicaid payment.

13. Occupational therapy services are limited to those cases identified and approved for children through a CHEC/EPSDT screen, or to a special group of services identified and approved through a cooperative occupational therapy/physical therapy program. Refer to the Medicaid Provider Manual for Child Health Evaluation and Care or for Physical Therapy.

14. Certain services or procedures are limited to prior authorization or are non-covered. Such procedures are identified in the Criteria for Surgical Procedures list included in this manual. This list will be updated by Medicaid Information Bulletins. When prior approval is required for a procedure, the requirement must be met whether the procedure is performed on an outpatient or inpatient basis. Approval is not limited to inpatient procedures.

    Here are two examples of how the prior approval requirement applies whether the procedure is performed on an outpatient or inpatient basis.
    - Written prior approval must be obtained prior to the implantation of a neurostimulator for partial epilepsy (345.41, 345.51) for both a hospitalized patient and a patient implanted with the device on an outpatient basis.

– An autologous bone marrow transplant procedure provided to the patient on an outpatient basis as a series of transplants or a mini bone marrow transplant must have written prior approval following the same criteria for prior authorization as an inpatient who receives a bone marrow transplant. Outpatient bone marrow transplants include lymphocyte infusion transplants, stem cell transplantation, or any other blood component when provided as a mini bone marrow transplant.

Effective January 1, 2002, facilities providing neurostimulator implantation for partial epilepsy or mini bone marrow transplantation must ensure the physician has obtained prior authorization. Should an audit find the procedure was not approved, payments may be recovered.

15. Outpatient Hospital Services are limited to 24 hours or less for services that are medically necessary and appropriate for the outpatient setting. Determinations of medical necessity and appropriateness are based on utilization management review and use of Inter-Qual medical review criteria as outlined in R414-1-12, Utah Administrative Code.

16. Observation or treatment room services are limited to cases where time is needed for observation and evaluation to establish a diagnosis and/or the appropriateness of an inpatient admission. Use of observation status to submit ancillary charges associated with outpatient surgery, other outpatient diagnostic services, or other outpatient stays for any reason is excluded form reimbursement.

    When a decision is made to admit a patient for inpatient service, as the end of the 24 hour observation time approaches, the severity of illness and intensity of service criteria must be completely met for the admission to be reimbursed.

    Under no circumstances can an observation stay be extended to more than 24 hours. It is not expected that a patient would be discharged in the event the 24 hour time limit would be reached after midnight or into the early morning hours, but the additional time does not warrant an additional day stay.

17. Outpatient hospital psychiatric services are limited to services provided in an outpatient unit of a general acute care hospital that is licensed and approved for psychiatric care.

18. Nonphysician psychosocial counseling services are limited to evaluations, and may be provided only through the Prepaid Mental Health Program by a licensed psychologist for:
    A. mentally retarded persons
    B. cases identified through a CHEC/EPSDT screening; or
    C. victims of sexual abuse

19. Lithotripsy, extracorporeal shock wave for treatment of kidney stones is covered by an all-inclusive fixed fee. This payment covers all hospital related services for lithotripsy on the same kidney for 90 days. No additional payment will be made for repeat procedures on the same kidney within the 90-day period.

    Lithotripsy for treatment of the kidney on the opposite side is considered a separate service. The same policy applies: payment covers all hospital related services for lithotripsy on the same kidney for 90 days.

20. Services reimbursed in the Emergency Department are limited to those codes and diagnosis listed in the Utah Medicaid Table of Authorized Emergency Diagnoses. The discharge diagnosis must be used and must be one of the first five diagnoses listed on the claim form.

    A. When the patient's medical needs are assessed and determined by the emergency room physician to be routine, (not of an emergency or urgent nature) the patient should be referred to the primary care physician for treatment. A Triage fee can be billed. When the triage fee is paid, no other medical care services will be paid by Medicaid for that date of service, to the same provider for the same triage encounter.

B. Emergency Services for Clients in a Managed Care Plan

Managed care plans, both HMOs and Prepaid Mental Health Plans (PHMP), are responsible for covering all emergency services for enrollees, regardless of where the emergency occurred and was treated. Providers who render emergency care to a patient enrolled in a managed care plan must obtain approval from the plan within the time frame specified by the plan, which is usually within 24 hours of service. (A list of telephone numbers for managed care plans is in the GENERAL ATTACHMENTS Section of this manual.) The provider will be reimbursed only when the provider has made a good faith effort to obtain approval from the plan within the time frame specified. If you do not have a contract with the plan responsible for the services, the plan may choose to transfer the patient to one of its contracting hospitals.

When the diagnosis is for emergency mental health services, and the patient is enrolled in a PMHP, bill the facility charge directly to Medicaid. The PMHP covers services, but not the facility charge.

This page reserved for future use.

4 NON-COVERED SERVICES

Certain services have been identified by Medicaid agency staff and medical review to be non-covered by the Utah Medicaid Program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of medical assistance under Title XIX of the federal Social Security Act and Title 42 Code of Federal Regulations (CFR). The general exclusions are listed below:

1. Services rendered during a period the client was ineligible for Medicaid.
2. Services medically unnecessary or unreasonable.
3. Services which fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature.
4. Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied.
5. Services, elective in nature, and requested or provided only because of the client's personal preference.
6. Services for which third party payors are primarily responsible, e.g., Medicare, private health insurance, liability insurance. Medicaid may make a partial payment up to the Medicaid maximum if limit has not been reached by third party.
7. Services fraudulently claimed.
8. Services which represent abuse or overuse.
9. Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above.
10. When a procedure or service is not covered for any of the above reasons or because of specific policy exclusion, all related services and supplies, including institutional costs will be excluded for the standard post operative recovery period.
11. Cosmetic, reconstructive, or plastic surgery procedures, including all services, supplies, and institutional costs related to services which are elective or desired primarily for personal, psychological reasons or as a result of the aging process.
12. Chemical peeling, dermabrasion or laser therapy of the face.
13. Removal of tattoos.
14. Hair transplants.
15. Breast augmentation or reduction mammoplasty.
16. Panniculectomy and body sculpturing procedures.
17. Rhinoplasty unless there is evidence of a recent accidental injury resulting in significant obstruction of breathing.
18. Procedures related to transsexualism.
19. Surgical procedures to implant prosthetic testicles or provide penile implants.

20. Certain services are excluded as family planning services:

    (1) Surgical procedures for the reversal of previous elective sterilization, both male and female

    (2) Infertility studies

    (3) In-vitro fertilization

    (4) Artificial insemination

    (5) Surrogate motherhood, including all services, tests, and related charges

    (6) Abortion, except when the life of the mother would be endangered, or when the pregnancy is the result of rape or incest.

21. Certain services are excluded from coverage because medical necessity, appropriate utilization, and cost effectiveness of the service cannot be assured. A variety of lifestyle factors contribute to the “syndromes” associated with such services, and there is no specific therapy or treatment identified except for those that border on behavior modification, experimental or unproven practices. Services include:

    (1) Sleep apnea, or sleep studies, or both.

    (2) Pain management, and pain clinic services..

    (3) Eating disorders.

22. An inpatient admission for 24 hours or more solely for observation or diagnostic evaluation is not a covered Medicaid service.

23. Nonphysician psychosocial counseling is not a covered Medicaid service. The personal supervision policy may not be applied to psychiatric or any other inpatient hospital services.

24. Miscellaneous supplies, dressings, durable medical equipment, and drugs to be used as take-home supplies are not covered Medicaid services.

25. Prescriptions to take home following inpatient or outpatient service are not a covered Medicaid benefit for persons with the designation “Emergency Services Only Program” printed on the Medical Identification Card.

26. Surgical procedures, unproven or experimental procedures, medications for appetite suppression, or educational, nutritional support programs for the treatment of obesity or weight control are noncovered Medicaid services.

5 BILLING

Effective July 1, 1998, Medicaid requires UB-92 inpatient and outpatient claims to be billed **electronically**. The Utah Medicaid agency will return UB-92 claims submitted on a paper form to the provider with a cover letter requesting the claim be submitted electronically.

A. Paper Claim Exceptions:

Medicaid accepts paper UB-92 claims in three circumstances only:

1. UB-92 claims billed by out-of-state providers
2. Dialysis claims
3. Crossover claims where the Medicare carrier is out of state

When necessary and appropriate to file a paper claim, refer to the Utah Uniform Billing Instruction Manual (UB-92 Manual) for the Utah Medicaid UB-92 Billing Instructions.

B. Electronic Billing with AcClaim Software

The Utah Health Information Network (UHIN) provides AcClaim software for billing UB-92 claims electronically. Providers who need AcClaim software and be set up to bill through UHIN may call (801) 466-7705. Providers who need additional assistance may call Medicaid Information, 538-6155 or toll-free 1-800-662-9651, and ask for Medicaid Electronic Billing.

The requirement to bill electronically through UHIN is supported by the Administrative Simplification Clause in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). An advantage of electronic billing for providers is that mistakes, such as placement of the provider number, can be corrected immediately. Because billing errors are reduced, claims can be processed without delays. Also, electronic claims can be submitted until noon on Friday for processing that week.

C. Crossover Claims with EOMB attachment

Mail Crossover claims with an Explanation of Medicare Benefits (EOMB) attachment **directly to** the Crossover agency agency at the address below.

Medicare/Medicaid Crossovers
Department 14X
P.O. Box 30269
Salt Lake City, UT 84130-0269

1. When Medicaid receives Crossover claims, they are routed to Blue Shield or returned to the provider. Crossover claims are processed by the Crossover agency, not by Medicaid.

2. Medicaid processes crossover claims in two circumstances only:

   A. Inpatient claim, Part B Only. After Medicare pays the claim, it is processed as a Medicaid claim with the Medicare payment on the claim. Medicaid then pays the Part A (hospital) charges.

   B. Out of plan claims such as mammography with the EOMB denial attached.

D. Manual Adjustments Accepted

When submitting a paper UB-92 claim as an adjustment to an original paid or denied claim, write the seventeen-digit transaction control number (TCN#) of the original claim on the paper claim or write **PAR** (Payment Adjustment Request) on the claim. The claim will be adjusted to correct billing errors or add charges.

INDEX for SECTION 2, Hospital Services